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CONNECTICUT HEALTH INSURANCE EXCHANGE BOARD MEETING

NOVEMBER 17, 2011

Mercer
2325 East Camelback, Phoenix, AZ 85016

MARSH & McLENNAN COMPANIES

Agenda

- Introduction of Mercer Team
- Goals for today
- Overview of all 11 planning project tasks
- Focused discussion on certain tasks
- Next steps
- Questions and answers

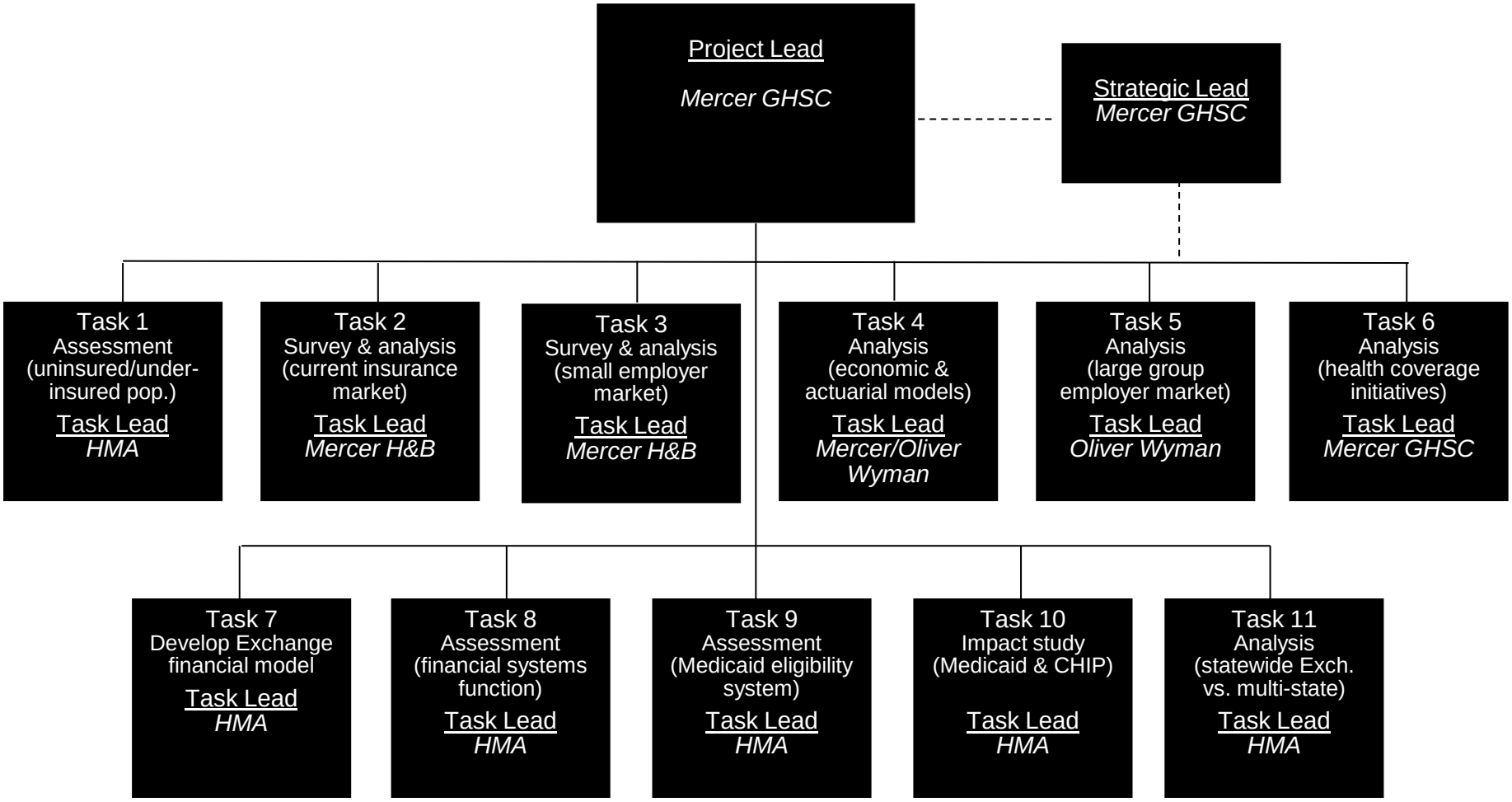
The Patient Protection and Affordable Care Act (PPACA)

- Provisions to create new competitive private health insurance markets known as Exchanges.
- Intent of the PPACA is that starting in 2014 Americans will have access to health coverage through these newly established Exchanges.
- Flexibility in the design and implementation of an Exchange – State specific.
- Small Business Health Options Program (SHOP).
- Purchase affordable health insurance from a choice of products offered by qualified health plans that facilitates competition and choice.

Mercer's planning efforts

- Since June 2011, Mercer has been researching and analyzing various components that impact the Exchange.
- Partners in this endeavor include:
  - Mercer Government Human Services Consulting
  - Mercer Health & Benefits Consulting
  - Oliver Wyman
  - Health Management Associates, Inc. (HMA)
- Collaborative effort - each bringing their own expertise to the project.

Partners


Project Lead
Mercer GHSC
Strategic Lead
Mercer GHSC
Task 1
Assessment (uninsured/under-insured pop.)
Task Lead
HMA
Task 2
Survey & analysis (current insurance market)
Task Lead
Mercer H&B
Task 3
Survey & analysis (small employer market)
Task Lead
Mercer H&B
Task 4
Analysis (economic & actuarial models)
Task Lead
Mercer/Oliver Wyman
Task 5
Analysis (large group employer market)
Task Lead
Oliver Wyman
Task 6
Analysis (health coverage initiatives)
Task Lead
Mercer GHSC
Task 7
Develop Exchange financial model
Task Lead
HMA
Task 8
Assessment (financial systems function)
Task Lead
HMA
Task 9
Assessment (Medicaid eligibility system)
Task Lead
HMA
Task 10
Impact study (Medicaid & CHIP)
Task Lead
HMA
Task 11
Analysis (statewide Exch. vs. multi-state)
Task Lead
HMA

Expectations for Exchange Board presentations

- Task discussion:
  - Overview
  - Background
  - Sources
  - Methodology
  - Results
  - Key Considerations
- The tasks will be divided between the November and December Board meetings.
- Questions and answers.
- Lay the foundation for the HIE planning decisions.

Expectations for today

- November 17 Board Meeting will cover the following tasks:
  - Overview of eleven tasks:
    - Detailed discussion on the following:
    - Task 4g – Benefit mandates
    - Task 8 – Technical requirements and development of specifications for accounting and financial system functions for the HIE
    - Task 9 – Assessment of the existing Medicaid eligibility system interface issues
    - Task 11 – Options for a multi-state and federal collaboration Exchange

Future Board meetings

- December board meetings will cover the remaining tasks:
  - Task 1 – Uninsured and underinsured
  - Task 2 – Survey the health insurance carriers
  - Task 3 – Survey the small employer market (<50 and 50–100 employees)
  - Task 4 – Review remaining economic and actuarial modeling and analyses
  - Task 5 –Large employer market (>100 employees)
  - Task 6 – Interaction with other coverage initiatives
  - Task 7 – Review a financial model for the HIE
  - Task 10 – Impact of the Medicaid program on the Exchange

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Overview of tasks

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Assessment of the uninsured and underinsured population in Connecticut

Task 1

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Task 1 – Assessment of the uninsured and underinsured population in Connecticut

- According to the 2008–2009 Census Bureau's Current Population Survey (CPS) dataset, the number of non-elderly uninsured individuals in Connecticut is estimated at 377,000 persons.

Distribution of the Nonelderly in Connecticut by Federal Poverty Level (FPL) and Coverage Source, 2008-2009 CPS Data with Kaiser/Urban Health Insurance Unit Adjustment

	Uninsured	Employer	Individual	Medicaid	Other Public	Total Population
Up to 138% FPL	155,700	116,300	37,900	198,900	23,900	532,800
Between 139% and 200% FPL	*65,400*	*85,700*	*18,300*	*58,000*	*9,700*	*237,000*
Total Up to 200% FPL	221,100	202,000	56,200	256,900	33,600	769,800
Above 200% FPL	155,900	1,863,100	93,000	95,500	17,100	2,224,500
Total	377,000	2,065,100	149,200	352,400	50,700	2,994,300

Task 1 – Assessment of the uninsured and underinsured population in Connecticut (cont'd)

- Factors that contribute to the uninsured estimate increasing or decreasing over time include:
  - Increased unemployment rate
  - Implementation of the Low Income Adult program under Medicaid in April 2010
  - Growth in enrollment in Medicaid and HUSKY programs since 2009
- The income stratification of the uninsured is a key component of identifying individuals that may qualify for subsidized coverage through the Exchange or be part of a Medicaid expansion.

Task 1 – Assessment of the uninsured and underinsured population in Connecticut (cont'd)

- Estimates vary for the number of State residents that are underinsured.
- There is no standard definition of underinsurance.
- Underinsurance factors can include:
  - High deductibles
  - Annual benefit limits
  - Treatment too costly

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Survey the health insurance carriers to better understand the types of plan designs being sold, the corresponding premium levels and the number of enrollees in each market segment (group and non-group)

Task 2

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Task 2 – Conduct a survey of the health insurance carriers that offer coverage to Connecticut residents

- The State of Connecticut has identified the health insurance carriers offering coverage in the State as an important stakeholder.
- Survey of the Connecticut insurance market will identify:
  - The predominant products being sold in the state by market segment
  - The designs of the products offered, including covered benefits, cost-sharing provisions and the premiums charged

Task 2 – Conduct a survey of the health insurance carriers that offer coverage to Connecticut residents (cont'd)

- The results will provide insight into:
  - Products being sold in the state by market segment
  - The designs of the products offered, including:
    - Covered benefits
    - Cost-sharing provisions
    - Premiums charged
  - Carrier market share information will provide insight into the competitiveness of Connecticut's health insurance market

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Survey the small employer market (<50 and 50–100 employees) to identify current and anticipated future benefit design needs and other issues

Task 3

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Task 3 – Conduct a survey of the small employer market (<50 and 50–100 employees) to identify current and anticipated future benefit design needs and other issues

- Understand the current and future needs of small employers.
- Focus groups.
  - Questions related to understanding what and how small employers are purchasing today, their future needs and HIE small employer policy questions were developed
  - 40+ randomly selected small employers

Task 3 – Conduct a survey of the small employer market (<50 and 50–100 employees) to identify current and anticipated future benefit design needs and other issues (cont'd)

- There is limited data available today on the current and future needs of small employers in Connecticut.
- Will the Exchange be able to attract small employers?
  - The ability of the Exchange to attract small employers depends upon the HIE board having a good understanding of today's small employer marketplace – how they buy, what they buy – and the board's adoption of policies that are responsive to current and future small employer needs

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Conduct economic and actuarial modeling and analyses to project trends such as the number of newly insured, the impact of certain market changes on premium levels and the implications of different policy questions

Task 4

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To integrate high risk pools in the non-group market or maintain high risk pools separately

Task 4a

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Task 4a – To integrate high risk pools in the non-group market or maintain high risk pools separately

- In 1975, Connecticut became one of the first states in the nation to establish a high risk pool, the Health Reinsurance Association (HRA).
  - Roughly 2,000 covered lives in HRA
  - Financed through a combination of premiums, assessments and federal grants
- PPACA §1101 established high risk pool for individuals with preexisting conditions.
  - 72 enrollees with no credible claims experience
  - Premiums set at 100% of standard rate

Task 4a – To integrate high risk pools in the non-group market or maintain high risk pools separately (cont'd)

- High risk pool members have higher than average medical claims.
- Funding in Connecticut is a mixture of assessments against health plans, member premium and federal grants.
- Connecticut also has a high risk pool for low income individuals that is funded, in part, by reimbursing providers at 75% of the Medicare reimbursement rate.
- High-risk pool members entering the non-group market will increase non-group premiums in 2014 unless assessments are maintained.

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Expand definition of small group from 50 to 100 prior to 2016

Task 4b

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Task 4b – Expand definition of small group from 50 to 100 prior to 2016

- PPACA defines “small employer” as being from 1 to 100, but gives states the option to define small employer as being from 1 to 50 employees until 2016 (PPACA §1301).
- Adding groups size 51 to 100 to the small group market could have consequences.
- Analysis will review carrier specific data.

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Impact of an Exchange on employer provided insurance and specifically the impact of employer penalties and tax credits by the different scenarios

Task 4c

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Task 4**c** – Impact of an Exchange on employer-provided insurance and specifically the impact of employer penalties and tax credits by the different scenarios

- Employers and employees will be considering the effect of the tax-advantaged nature of employer-provided health insurance compared to the premium tax credits available through the Exchanges.
- Employers will face significantly different situations – likely resulting in significantly different responses – due to the level of their employees' income.
- The introduction of employer-shared responsibility penalties and the availability of income-related subsidies for employees not covered by employer-provided insurance.

Task 4**c –** Impact of an Exchange on employer provided insurance and specifically the impact of employer penalties and tax credits by the different scenarios (cont'd)

- Individuals with current employer-sponsored insurance will have the option to enter the Individual Exchange if their employer terminates coverage.
- Tax credits will reduce premium costs.
- There are subsidies to lower cost sharing.
- Affordability is based on the employee's wages and the contribution required for single coverage.

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Merging the small group and individual markets

Task 4d

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Task 4d – Merging the small group and individual markets

- The insurance market reforms and other provisions of PPACA may lead to significant premium changes both across a market and within a market – there will be winners and losers.
  - Factors contributing the premium changes include:
    - Modified community rating
    - Transitional reinsurance program
    - Guarantee issue in the small and non-group markets
- PPACA gives states the option of merging the small group and non-group markets if the “State determines it appropriate” (PPACA §1312).

Task 4d – Merging the small group and individual markets (cont'd)

- Effects of these provisions of PPACA will depend on:
  - Current rating practices
  - Respective size of the small group and individual markets
- Effects in Connecticut's small group market will be less than in many other states due to requirement for modified community rating.

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Impact of the individual mandate to purchase health insurance and its influence on the market and the assumptions made in that regard with respect to the models

Task 4e

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Task 4e – Impact of the individual mandate to purchase health insurance and its influence on the market and the assumptions made in that regard with respect to the models

- PPACA includes a requirement that individuals maintain “minimum essential coverage” or face a penalty.
- The mandate is not universal, providing a penalty exemption.
- The penalty is the larger of the flat annual penalty or the percent of income.

Task 4e – Impact of the individual mandate to purchase health insurance and its influence on the market and the assumptions made in that regard with respect to the models (cont'd)

- HCR Model based on Health Insurance Unit (HIU), not household.
- HIU decisions based on maximizing "utility."
  - Utility is defined as the total satisfaction a consumer receives from consuming a good or service
- The simulation process incorporates a utility function consisting of four variables reflecting health status and income:
  - Net premium
  - Expected out-of-pocket costs – Varies with insurance option being evaluated
  - Variance of expected out-of-pocket cost (risk aversion) – Also varies with insurance option being evaluated
  - Value of expected health care consumed

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Impact to markets and the Exchange if the Basic Health Plan option is considered

Task 4f

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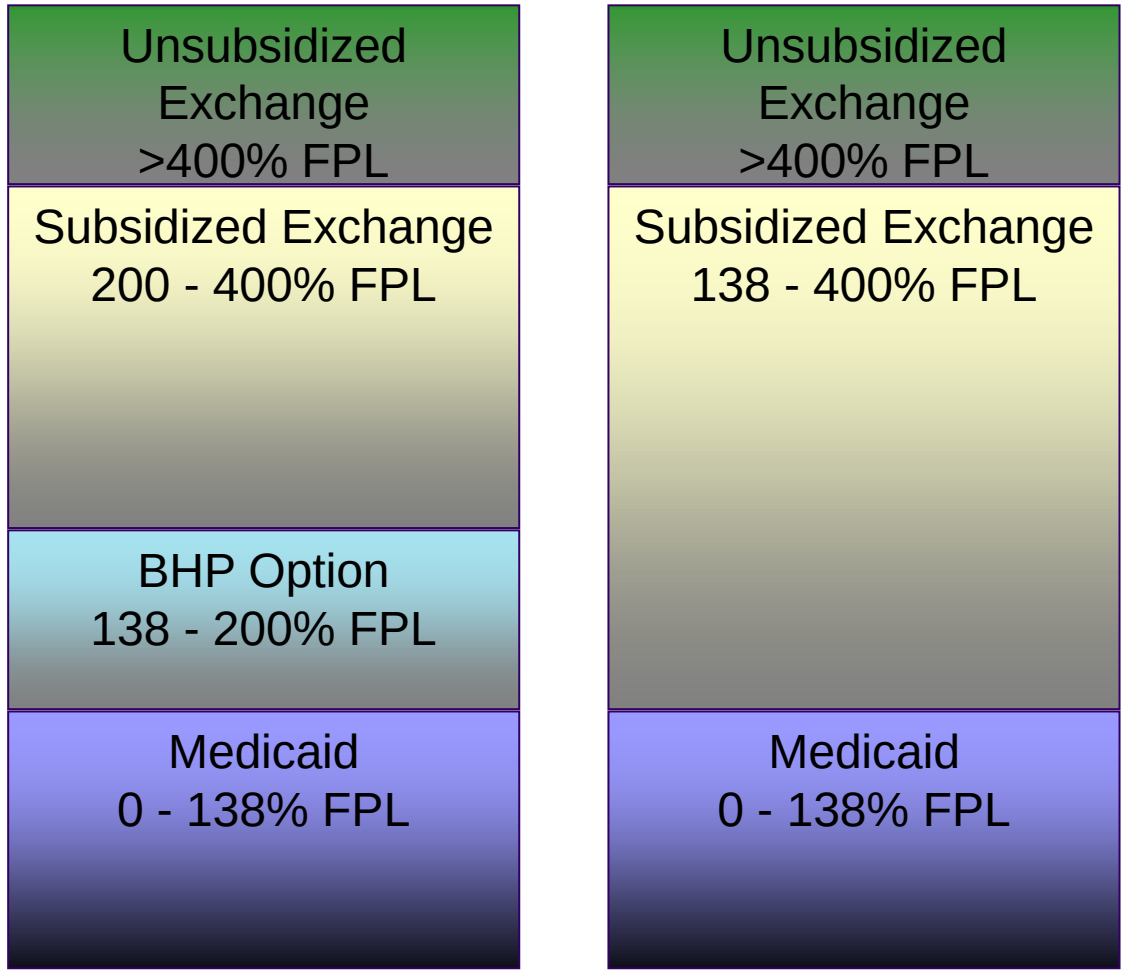
Task 4f – Impact to markets and the Exchange if the Basic Health Plan option is considered

- The provisions of the Basic Health Plan (BHP) in the PPACA was modeled after Washington State's BHP.
- Federal government will provide states with 95% of the subsidies it would have provided to this population in the Exchange, from which the states can fund a BHP.
- The Basic Health Program allows states the option of covering the non-Medicaid low-income population below 200% FPL using its Medicaid or Medicaid-like infrastructure.

Task 4f – Impact to markets and the Exchange if the Basic Health Plan option is considered (cont'd)

- Either/Or option – Those below 200% FPL would be enrolled in a BHP and would not be eligible for the Exchange.
- Premiums and cost sharing must be less than or equal to what would be available to this population in the Exchange.
- The feasibility of the BHP option is based on the size of the differential between a state's Medicaid provider reimbursement rates and the prevailing commercial rates.
- Implementing a BHP removes the 138%–200% FPL population from the pool of those eligible to enroll in the Exchange.
  - Reduces the size of the Exchange
  - Modifies the composition of the Exchange risk pool (impact unknown)
- Advantages of implementing a BHP:
  - Reduce premiums and cost sharing for this low-income population
  - Encouraging more people to enroll and receive care

Task 4f – Impact to markets and the Exchange if the Basic Health Plan option is considered (cont'd)



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The cost of Connecticut benefit mandates that are above the federal essential benefits in the context of a revised insurance market

Task 4g

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Task 4g – The cost of Connecticut benefit mandates that are above the federal essential benefits in the context of a revised insurance market

- State benefit mandates can provide significant patient protections to consumers.
- Connecticut ranked number 5 in the nation in the number of health mandates in 2010 (CAHI Report).
- Section 1311(d)(3)(B) of PPACA says that states may require qualified health plans offered in exchanges to cover additional benefits not included in the essential health benefits package; however, states will have to assume the costs associated with these additional requirements.
- Each state will need to balance the significance of patient protections associated with its mandates versus the potential cost to the state in maintaining these mandates once the exchanges are in operation.
- You will hear more about the specifics of this task after the general overview is completed.

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Impact of the Exchange on insurer profitability and potential market exit

Task 4h

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Task 4h – Impact of the Exchange on insurer profitability and potential market exit

- Connecticut's insurance market is concentrated with five companies controlling roughly 85% of the market.
- Several smaller companies with very little business.
- With few exceptions, loss ratios are consistent with federal minimum requirements.

Task 4h – Impact of the Exchange on insurer profitability and potential market exit (cont'd)

- PPACA eliminates the means by which a number of carriers competed for small group and individual business:
  - Guarantee issue removes ability of carriers to use sophisticated underwriting systems to select risks
  - Minimum loss ratio provisions make paying high commission problematic
  - Price transparency that will come from Exchange will also prove problematic for certain carriers – particularly those with small market share and potentially overly-broad networks

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Impact of the Exchange on household budgets

Task 4i

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Task 4i – Impact of the Exchange on household budgets

- PPACA includes a number of provisions that will impact household budgets:
  - Premium subsidies
  - Cost sharing subsidies
  - Coverage at certain minimum actuarial values
  - States could enhance subsidies with their own funds
- Healthcare spending tends to be concentrated among relatively few high-cost individuals; so even with these provisions, looking at average spending and its impact on household budgets can be misleading.

Task 4i – Impact of the Exchange on household budgets (cont'd)

- Healthcare spending concentrated among relatively few, high-cost individuals.
- Rate of underinsurance will increase with the cost of health care.
- Health insurance costs will increase more rapidly than incomes.

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Large employer market in Exchanges post 2017

Task 5

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Task 5 – Large employer market in Exchanges post 2017

- Connecticut's insurance market is concentrated with five companies controlling roughly 85% of the market.
- Several smaller companies with very little business.
- With few exceptions, loss ratios are consistent with federal minimum requirements.
- PPACA gives states the flexibility to allow large groups to purchase insurance in the Exchange beginning in 2017.

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Analyze the impact of the Exchange in regards to interaction with other health coverage initiatives in Connecticut

Task 6

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Task 6 – Analyze the impact of the Exchange in regards to interaction with other health coverage initiatives in Connecticut

- The analysis considered a wide range of health systems expected to exist in the marketplace at the time of the Exchange.
- Some of these systems have been around for years and others are now just being planned.
- The Exchange functions as the hub of service delivery.

Task 6 – Analyze the impact of the Exchange in regards to interaction with other health coverage initiatives in Connecticut (cont'd)

- The health systems analyzed are varied and include public and private systems.

Health Coverage Initiatives Examined
Partnership Plans
Health Connections
Pre-existing Condition Health Insurance Plan
Charter Oak
Connecticut AIDS Drug Assistance Program (CADAP)
HUSKY B > 300% FPL

Task 6 – Analyze the impact of the Exchange in regards to interaction with other health coverage initiatives in Connecticut (cont'd)

- Analyze the interaction of other health systems in Connecticut with the Exchange.
- Exchange cannot operate in isolation.
- Exchange cannot be effective without information and appropriate levels of interaction with other health systems in Connecticut.
- Prevent duplication of service delivery.
- Reduce administrative costs.
- Provide improved customer service for Connecticut residents.

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Develop a financial model for the Exchange (cash flow) to understand the administrative charges necessary to be financially self-sustaining by January 2015 and offer recommendations regarding the options to receive such charges

Task 7

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Task 7 – Develop a financial model for the Exchange

- Affordable Care Act requires Exchanges to be financially self-sustaining by January 1, 2015.
- State needs to recognize that Exchange cost is contingent upon a number of unknown factors.
  - Assumed Exchange membership
  - Administrative structure of the Exchange
  - Mandates in authorizing legislation (Public Act 11-53)
- Budget model needs to address this uncertainty in its initial estimate.
- State must be able to adjust cost estimates to reflect changes in major inputs.

Task 7 – Develop a financial model for the Exchange (cont'd)

- Develop a model projecting Exchange operating costs and potential revenues.
- Model will incorporate estimates of Exchange cash flow and reserve amounts to support financial self-sufficiency by 2015.
- Model will test a number of potential revenue sources against projected Exchange operating costs.

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Assess the technical requirements and development of specifications for accounting and financial system functions for the Exchange

Task 8

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Task 8 – Assess the technical requirements and development of specifications for accounting and financial system functions for the Exchange

- Assess capabilities of pertinent state-owned and operated information systems against federal guidance, specifically *Core-CT (PeopleSoft).*
- Identify potential for leveraging capabilities of Core-CT in support of the Exchange.
  - Exchange financial management functions per the ACA, including premium management, subsidy administration, risk management
  - Administrative functions of the Exchange entity: financial accounting, supply chain management, asset management, HR/payroll, etc.
- You will hear more about the specifics of this task after the general overview is completed.

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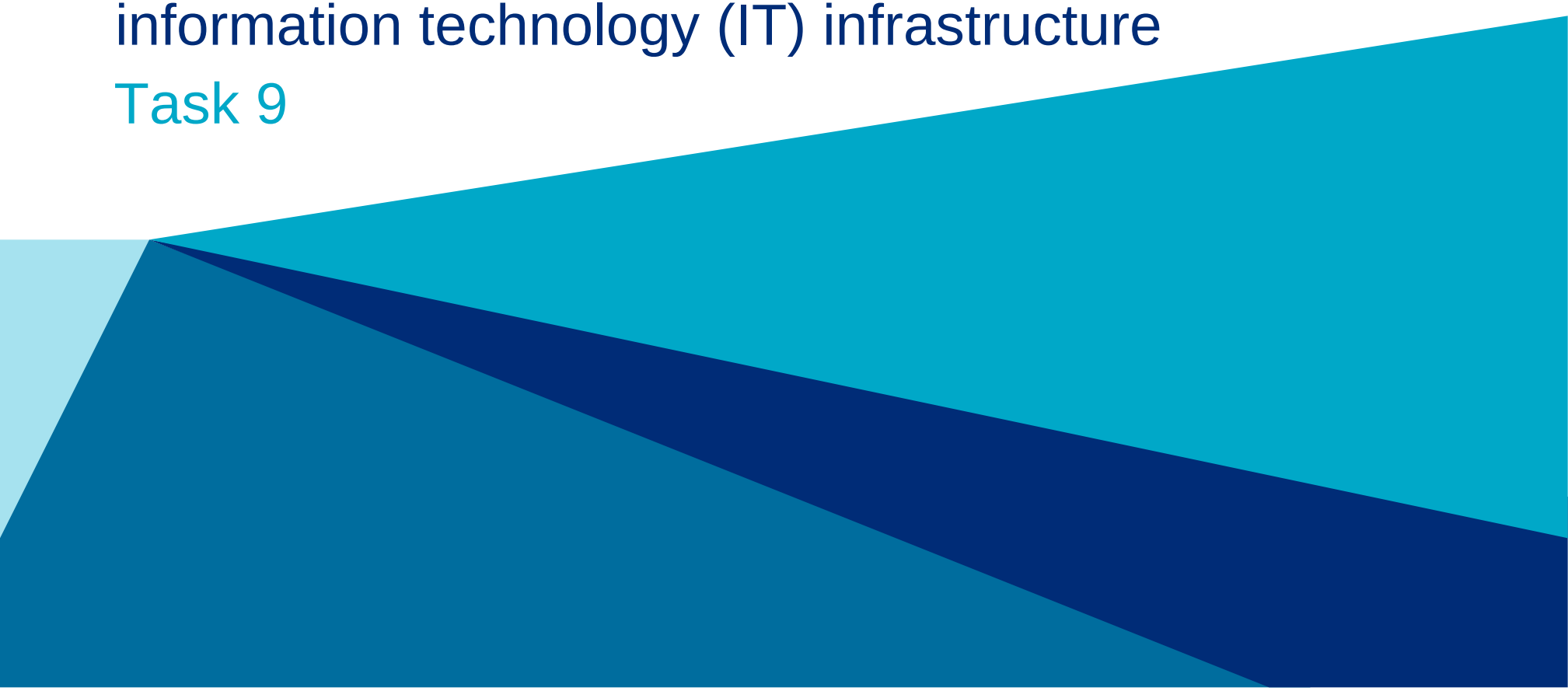
Assess existing Medicaid eligibility system and identify interface issues and necessary requirements for integration with the Exchange information technology (IT) infrastructure

Task 9



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Task 9 – Assess existing Medicaid eligibility system and identify interface issues and necessary requirements for integration with the Exchange information technology (IT) infrastructure

- Assess capabilities of pertinent state-owned and operated information systems against federal guidance, specifically *EMS.*
- Identify potential for leveraging capabilities of these systems in support of an Exchange.
- You will hear more about the specifics of this task after the general overview is completed.

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Medicaid/CHIP impact analysis

Task 10

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Task 10 – Medicaid/CHIP impact analysis

- Summary
  - PPACA covers nearly all individuals under the age of 65 with household incomes up to 133% of the FPL.
  - Medicaid will likely see an increase in enrollment from one or more populations.
  - Certain populations currently in Medicaid programs may transition to new PPACA programs (e.g., health insurance exchange, Basic Health Program) effective January 1, 2014.

Task 10 – Medicaid/CHIP impact analysis (cont'd)

- New coverage.
- Modified adjusted gross income.
- Enhanced federal financial participation.
- New alternatives for existing Medicaid enrollees.

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Analysis of the benefits of a multi-state Exchange or other opportunities to collaborate on Exchange development and operations

Task 11

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Task 11 – Analysis of the benefits of a multi-state Exchange or other opportunities to collaborate on Exchange development and operations

- Section 1311 of the PPACA allows states to join with other states (regionally or otherwise) to jointly operate exchanges.
- Federal effort to get states involved in exchange implementation.
- Connecticut is a member of the NESCIES project, an “Early Innovator” Grant project.

Task 11 – Analysis of the benefits of a multi-state Exchange or other opportunities to collaborate on Exchange development and operations (cont'd)

- Multi-state exchange operation creates regulatory, legal and practical issues.
- Options for Connecticut to leverage external resources for Exchange operation.
  - Utilizing a federal partnership model
  - Accessing IT functionality from the NESCIES project
- The value of federal partnership models is difficult to assess with current information from CCIIO.
- You will hear more about the specifics of this task after the general overview is completed.

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Questions and answers

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Task presentations

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Overview

- Each of these tasks will help lay the foundation for Connecticut's Health Insurance Exchange planning.
- Each will help guide the state in your future planning.
- Detailed discussion on completed tasks will now begin.

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The cost of Connecticut benefit mandates that are above the federal essential benefits in the context of a revised insurance market

Task 4g – Detailed discussion

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Task 4g – Connecticut benefit mandates

- Background
  - State benefit mandates can provide significant patient protections to consumers
  - Connecticut ranked number 5 in the nation in the number of health mandates in 2010 (CAHI Report)
  - Section 1311(d)(3)(B) of PPACA says that states may require qualified health plans offered in exchanges to cover additional benefits not included in the essential health benefits (EHB) package; however, states will have to assume the costs associated with these additional requirements
  - Each state will need to balance the significance of patient protections provided by each mandate versus the potential cost to the state in maintaining these mandates once the exchanges are in operation

Task 4g – Connecticut benefit mandates (cont'd)

- Legislation
  - The essential health benefits shall include at least the following general categories and the items and services covered within the categories:
    - Ambulatory patient service
    - Emergency service
    - Hospitalization
    - Maternity and newborn care
    - Mental health and substance use disorder services, including behavioral health treatment
    - Prescription drugs
    - Rehabilitative and habilitative services and devices
    - Laboratory services
    - Preventive and wellness services and chronic disease management
    - Pediatric services, including oral and vision care

Task 4g – Connecticut benefit mandates (cont'd)

- Legislation (cont'd)
  - Benefit reforms already implemented or that are scheduled to be implemented:
    - Phase-in of elimination of annual and lifetime limits to be completed by 2014
    - Provide preventive services with no cost sharing for specified preventive care services including immunizations
    - Freedom to select primary care physician (PCP) for plans requiring a designated PCP
    - Access to pediatric care by allowing a pediatrician to be eligible for PCP status
    - Access to emergency care at in-network cost sharing levels
    - Access to OB/GYNs without a referral
    - Coverage for children to age 26 under a parent's policy
    - Guarantee issue of coverage without pre-existing condition exclusions for children under age 19

Task 4g – Connecticut benefit mandates (cont'd)

- Legislation: PPACA Section 1302
  - Additional guidelines for EHB:
    - Be reflective of a "typical employer plan"
    - Incorporate a set of "required elements for consideration" such as balance and nondiscrimination

Task 4g – Connecticut benefit mandates (cont'd)

- Institute of Medicine (IOM) Report Summary
  - Report issued October 7, 2011
    - Provides recommendations for a process HHS can use to develop the initial EHB and to provide subsequent modifications
    - Does not recommend a specific EHB

"The Institute of Medicine was asked by the Secretary to make recommendations on the methods for determining and updating the essential health benefits. Notably, the request was to focus on criteria and policy foundations for the determination of the EHB, not to develop the list of benefits."

– IOM Report, Abstract

Task 4g – Connecticut benefit mandates (cont'd)

- IOM Report Summary (cont'd)
  - State mandates
    - State mandates should not receive special treatment but should be subject to the same inclusion criteria as any other service or item

"*Because state mandates are not typically subjected to a rigorous evidence-based review or cost analysis, cornerstones of the committee's criteria, the committee does not believe that state-mandated benefits should receive any special treatment in the definition of the EHB and should be subject to the same evaluative method. This interpretation is consistent with the language in ACA regarding state mandates; that is, Congress did not require their inclusion.*"

– IOM Report, Chapter 4

Task 4g – Connecticut benefit mandates (cont'd)

- IOM Report Summary (cont'd)
  - Typical employer plan
    - The IOM recommends that the starting point in establishing the initial EHB package should be the scope of benefits and design provided under a typical small employer plan in today's market

"*Available data suggest the profile of covered benefits among large and small employers and the average premium paid is often not great; benefit design choices play a greater role. Given the ACA's focus on providing access to health insurance for workers of small firms and individuals in the opening years of the health insurance exchanges, the committee concluded that the initial focus of the EHB definition be one that would be typical in the small employer market.*"

– IOM Report, Chapter 4

Task 4g – Connecticut benefit mandates (cont'd)

- IOM Report Summary (cont'd)
  - Affordability and sustainability
    - Develop a balance between making coverage available for individuals to get the care they need at a cost they can afford

"Without some constraint on the size of the EHB package, the premium prices faced by individuals seeking to obtain coverage both inside and outside of the exchanges in the individual and small business market may prove unaffordable to the target population and diminish access to health insurance coverage. The committee concludes that EHB should be defined as a package that will fall under a predefined cost target rather than building a package and then finding out what it would cost."

– IOM Report, Chapter 4

Task 4g – Connecticut benefit mandates (cont'd)

- IOM Report Summary (cont'd)
  - Affordability and sustainability
    - Develop a *national* target premium

"*Once a preliminary EHB list is developed …, the package should be adjusted so that the expected national average premium for a silver plan with the EHB package is actuarially equivalent to the average premium that would have been paid by small employers in 2014 for a comparable population with a typical benefit design.*"

– IOM Report, Chapter 5

Task 4g – Connecticut benefit mandates (cont'd)

- IOM Report Summary (cont'd)
  - Criteria to guide specific EHB content
    - The individual service, device, drug for the EHB must:
      - Be safe
      - Be medically effective
      - Demonstrate meaningful improvement
      - Be a medical service (not serving primarily a social or educational function)
      - Be cost effective

– Essential Health Benefits Criteria, IOM

Task 4g – Connecticut benefit mandates (cont'd)

- IOM Report Summary (cont'd)
  - Criteria to guide specific EHB content
    - Caveats
      - Failure to meet any of the criteria should result in exclusion or significant limits on coverage
      - Each component would still be subject to the criteria for assembling the aggregate EHB package
      - Inclusion does not mean that it is appropriate for every person to receive every component

– Essential Health benefits Criteria, IOM

Task 4g – Connecticut benefit mandates (cont'd)

- IOM Report Summary (cont'd)
  - Covered services
    - Every service or item that might be classified within the 10 categories or the typical employer plan is not essential

"The committee concludes, that the section 1302 language that says 'the items and services covered within the categories' should not be read to mean that every service that is within one of the 10 categories or is covered by a typical employer plan should automatically be included within the definition of the EHB."

– IOM Report, Chapter 4

Task 4g – Connecticut benefit mandates (cont'd)

- Summary – Benefit mandates
  - Resources
    - Connecticut Statutes: Chapter 700c – Health Insurance
    - University of Connecticut/Ingenix Consulting Report 2010
    - University of Connecticut/Ingenix Consulting Report 2011
    - Utilizes claims data representing 90% of Connecticut's fully insured population
    - The group data is more credible than the individual data
    - For purposes of the presentation, point estimates rather than cost ranges are displayed, reflecting the full cost for each mandate
    - These reports were not intended to specifically assess the impact of PPACA

Task 4g – Connecticut benefit mandates (cont'd)

- Summary – Benefit mandates (cont'd)

	Individual mandates		Group mandates	
	Count	Percent of claims	Count	Percent of claims
EHB	9	9.1%	9	10.6%
Unknown	28	8.2%	31	10.4%
Total	37	17.2%	40	21.0%

– Totals may not sum due to rounding.
– Reflective of 2010 claims cost projections.

  - EHB – Assumed to be an Essential Health Benefit
  - Unknown – All, none or a part of the mandate may eventually be defined as an Essential Health Benefit (pending clarification from HHS)

Task 4g – Connecticut benefit mandates (cont'd)

- Summary – Benefit mandates (cont'd)
  - Why the "Unknown" classification?"
    - Final detailed EHB guidance expected no later than next May
    - IOM recommendation for a predefined cost target
    - Recommended EHB evaluation criteria is multi-dimensional
    - Flexible definition of covered service
    - Allowances for benefit limits
    - Allowances for policy exclusions
    - Mandates are multi-faceted
    - State innovation
      - Permissible for states operating their own exchanges

Task 4g – Connecticut benefit mandates (cont'd)

- Summary – Benefit mandates (cont'd)
  - Assumed to be an essential health benefit – Individual and group markets

Count	Policy Statute	Description	Percent of Claims	
			Individual	Group
1.	Sec. 38a-490; Sec. 38a-516	Coverage for newborn infants	1.9%	1.7%
2.	Sec. 38a-490d; Sec. 38a-535	Blood lead screening, risk assessment, and Preventative Pediatric Care	0.0%	0.6%
3.	Sec. 38a-492d; Sec. 38a-518d	Diabetes testing and treatment	0.3%	1.5%
4.	Sec. 38a-492g; Sec. 38a-518g	Prostate cancer screening	0.1%	0.1%
5.	Sec. 38a-492k; Sec. 38a-518k	Colorectal cancer screening.	0.8%	1.1%
6.	Sec. 38a-503; Sec. 38a-530	Mammography and breast ultrasound	0.9%	0.9%
7.	Sec. 38a-503c; Sec. 38a-530c	Maternity minimum stay	0.6%	0.6%
8.	Sec. 38a-503e; Sec. 38a-530e	Prescription contraceptives	0.4%	0.4%
9.	Sec. 38a-504; Sec. 38a-542	Tumors and leukemia, wigs, breast reconstruction*	4.1%	3.7%
Total			**9.1%**	**10.6%**

– Totals may not sum due to rounding.

• Wigs may be excluded from the EHB; however, the proportion of costs attributable to this benefit within this mandate is negligible.

Task 4g – Connecticut benefit mandates (cont'd)

- Summary – Benefit mandates (cont'd)
  - Unknown: The extent to which these mandates may ultimately be covered in the final EHB is unknown – Individual market

Count	Policy statute	Description	Percent of claims
1.	Sec. 38a-488a	Mental or nervous conditions	2.7%
2.	Sec. 38a-476b	Psychotropic drug availability	1.9%
3.	Sec. 38a-492b	Off-label use of cancer drugs	0.9%
4.	Sec. 38a-509	Infertility diagnosis and treatment	0.7%
5.	Sec. 38a-498	Ambulance services	0.6%
6.	Sec. 38a-493	Home health care	0.4%
7. – 28.	All other	All other	1.1%
Total			**8.2%**

– Totals may not sum due to rounding.

Task 4g – Connecticut benefit mandates (cont'd)

- Summary – Benefit mandates (cont'd)
  - Unknown: The extent to which these mandates may ultimately be covered in the final EHB is unknown – Group market

Count	Policy statute	Description	Percent of Claims
1.	Sec. 38a-514	Mental or nervous conditions	2.8%
2.	Sec. 38a-476b	Psychotropic drug availability	2.5%
3.	Sec. 38a-518b	Off-label use of cancer drugs	1.0%
4.	Sec. 38a-536	Infertility diagnosis and treatment	0.9%
5.	Sec. 38a-523	Comprehensive rehabilitation services (mandatory offer)	0.8%
6.	Sec. 38a-525	Ambulance services	0.8%
7. – 31.	All other	All other	1.6%
Total			**10.4%**

– Totals may not sum due to rounding.

Task 4g – Connecticut benefit mandates (cont'd)

- Case study
  - State benefit mandate – Lyme disease treatments
    - Provides coverage for specific Lyme disease treatment
    - The mandate exceeds recommended treatment therapies
    - The prevalence of Lyme disease is very high in Connecticut compared to the national average
    - The estimated costs when spread over the fully insured population is negligible

Task 4g – Connecticut benefit mandates (cont'd)

- Summary – Provider mandates

"The ACA prohibits insurers from discriminating on the basis of type of provider as long as the provider is operating within its scope of practice; however, this is a separate issue from defining specific types of services as being part of the EHB package."

– Institute of Medicine

Task 4g – Connecticut benefit mandates (cont'd)

- Summary – Provider mandates (cont'd)
  - Individual and group markets

Count	Policy statute	Description	Percent of claims	
			Individual	Group
1.	Sec. 38a-492i; Sec. 38a-518i	Mandatory coverage for pain management	0.0%	0.0%
2.	Sec. 38a-498b; Sec. 38a-525b	Mandatory coverage for mobile filed hospital	0.0%	0.0%
3.	Sec. 38a-499; Sec. 38a-526	Mandatory coverage for services of physician assistants and certain nurses	0.0%	0.0%
4.	Sec. 38a-502; Sec. 38a-529	Mandatory coverage for services provided by the Veteran's Home	0.1%	0.1%
5.	Sec. 38a-503b; Sec. 38a-530b	Carriers to permit direct access to obstetrician-gynecologist*	0.0%	0.0%
6.	Sec. 38a-507; Sec. 38a-534	Mandatory coverage for chiropractic services	0.6%	0.8%
Total			**0.7%**	**1.0%**

– Totals may not sum due to rounding.

* This mandate is assumed to be covered as a benefit reform as identified in the ACA.

Task 4g – Connecticut benefit mandates (cont'd)

- Key considerations
  - Patient protections (medical efficacy, social implications)
  - Continue to introduce new benefit mandates
  - Considerations for maintaining the benefit mandates
    - Administrative burden
    - Cost to fund the mandates borne by the State
    - Mandatory offer mandates, provider mandates
    - Alignment with IOM recommendations related to future costs of the EHB
    - Potential complications with risk mitigation features of the ACA such as risk adjustment
    - What level of detail will be provided by HHS related to the EHB

"Initial guidance by the Secretary on the contents of the EHB package should list standard benefit inclusions and exclusions at a level of specificity at least comparable to current best practices in the private and public insurance market." – IOM Report, Chapter 5

Task 4g – Connecticut benefit mandates (cont'd)

- Key considerations (cont'd)
  - Consider IOM recommendations for future cost targets
    - Obtain an actuarial estimate of the national average premium for a Silver Level plan with the existing EHB for the next year
    - Adjust for trends in medical prices, utilization, new technologies and population characteristics
    - Any changes to the EHB cannot result in costs that exceeds the actuarially estimated cost of the current package in the next year

Task 4g – Connecticut benefit mandates (cont'd)

- Options
  - Await further guidance from HHS to define the EHB
    - Re-evaluate the impact to the mandated benefits
  - Maintain all existing and newly introduced mandates
  - Review and modify specific mandates based on economic, social and medical efficacy criteria
  - Mandatory offer mandate
    - Make this an actual benefit mandate
    - Repeal this mandatory offer mandate

Questions and answers for Task 4g

MERCER

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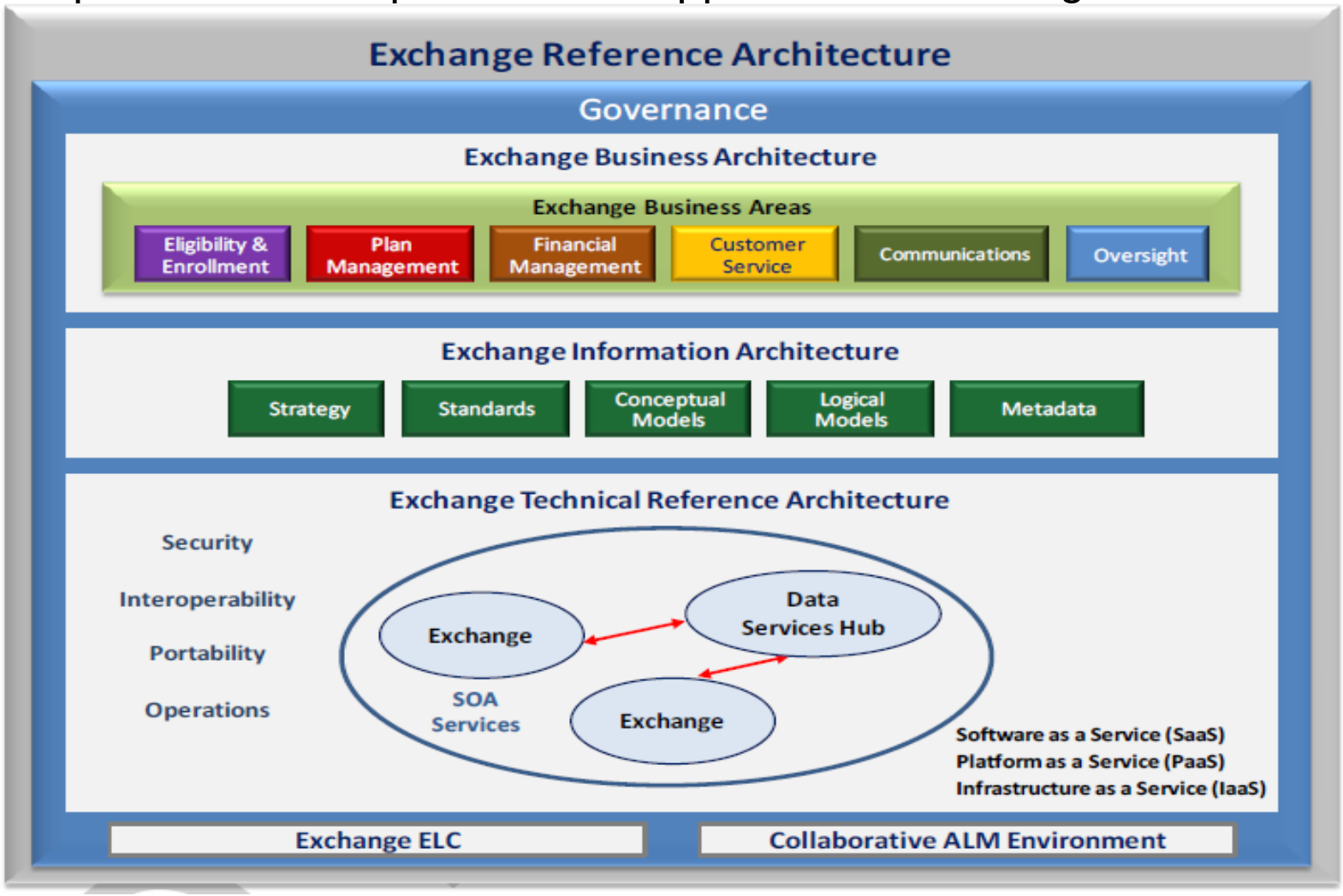
Background – Exchange information systems

CMS perspective and guidance

MARSH & McLENNAN COMPANIES

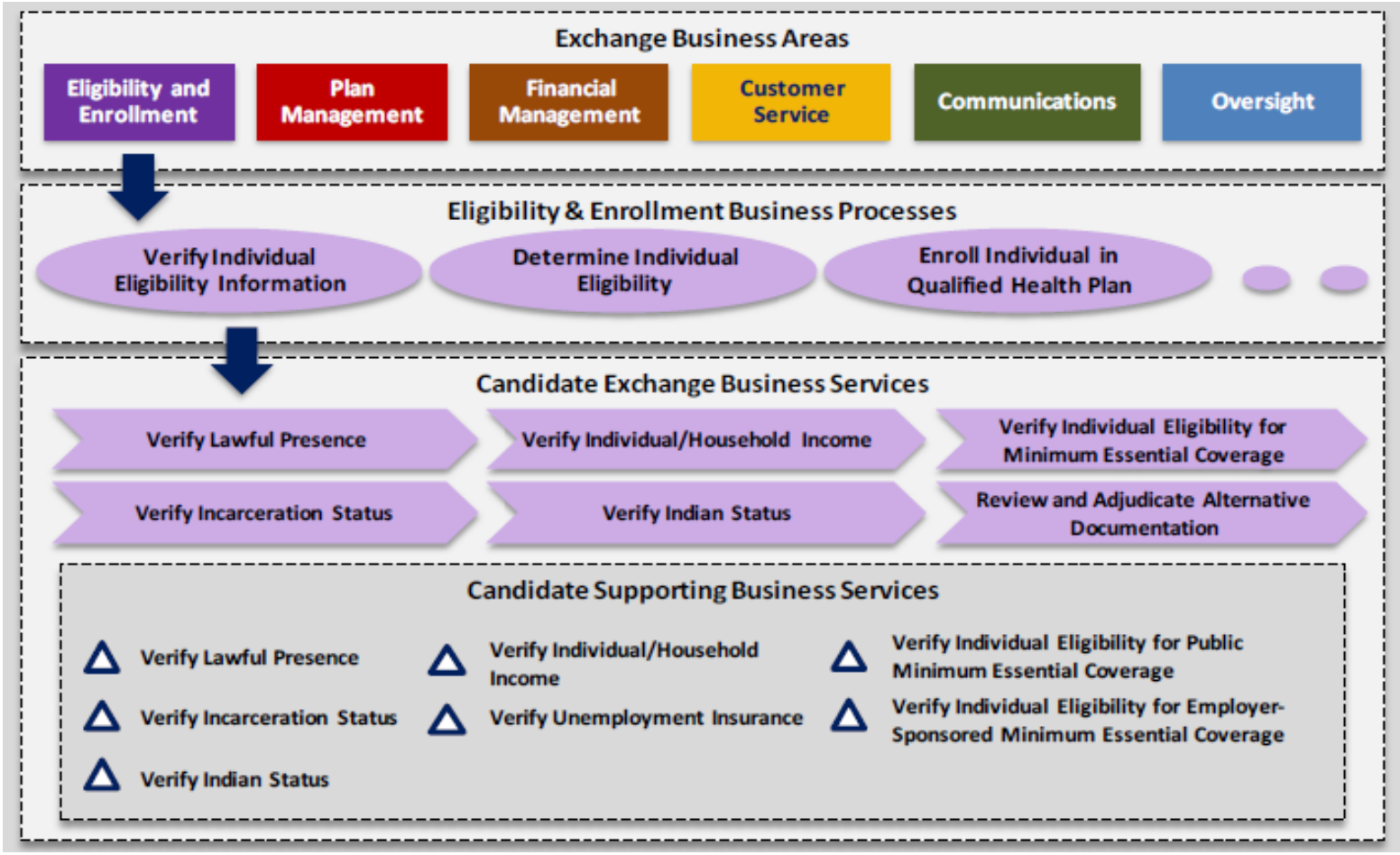
Exchange information systems – CMS perspective and guidance
Exchange reference architecture

- Framework developed by CMS to facilitate requirements definition, analysis and acquisition of IT capabilities in support of an Exchange.



Exchange information systems – CMS perspective and guidance
Exchange reference architecture (cont'd)

- Key tenets:
  - Business capability requirements drive IT requirements
  - IT capabilities as "modules/components" for assembly, integration and reuse



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Assess existing Medicaid eligibility system and identify interface issues and necessary requirements for integration with the Exchange information technology (IT) infrastructure

Task 9 – Detailed discussion

Task 9 – Assess existing Medicaid eligibility system and identify interface issues and necessary requirements for integration with the Exchange information technology (IT) infrastructure

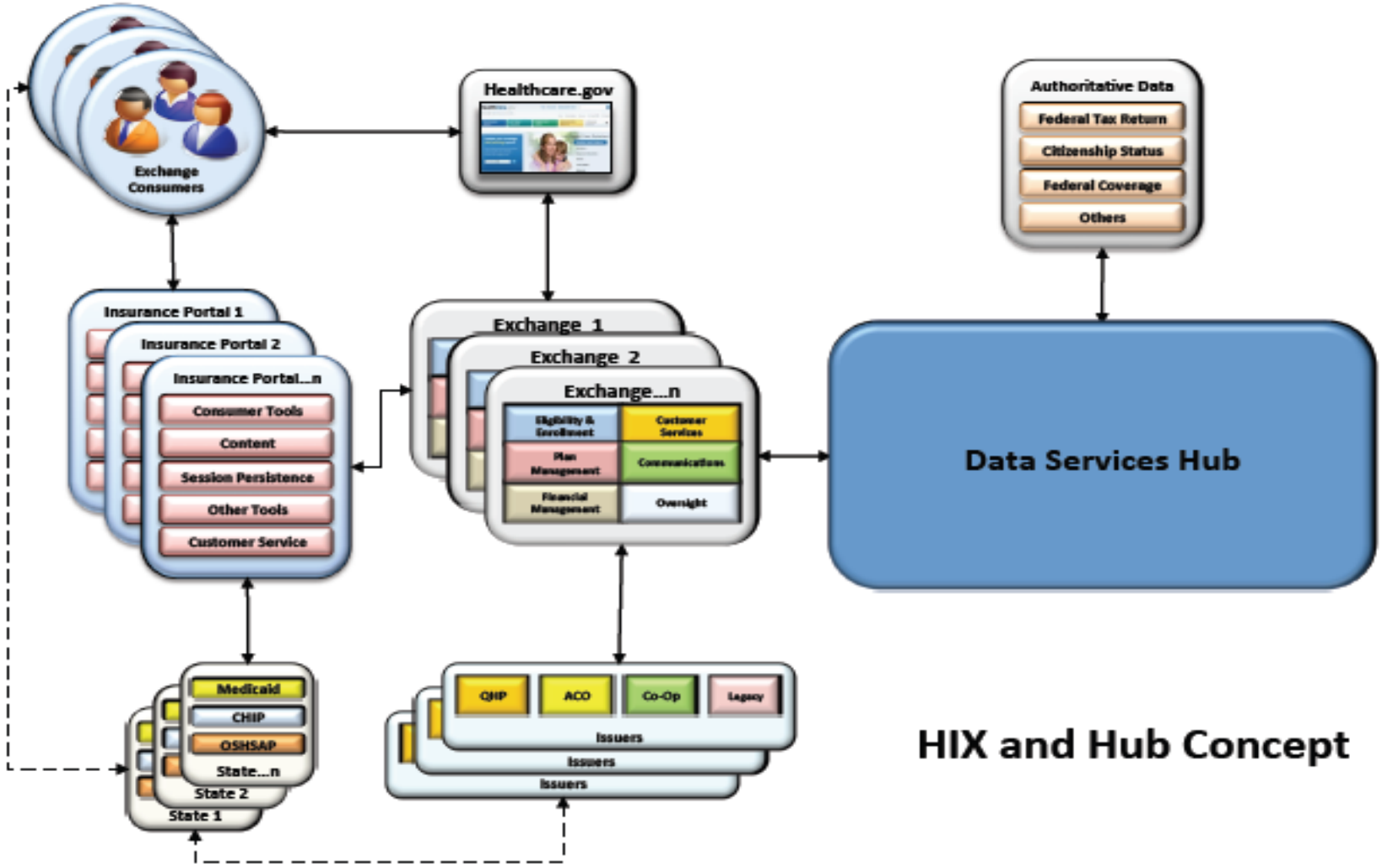
- Overview
  - In the last several months CMS has issued guidance regarding Exchange eligibility and enrollment business process and information systems requirements
  - Included in this guidance is the expectation that the Exchange must be able to process eligibility determinations for Medicaid and CHIP
  - Previously CMS issued more high-level guidance which applied to Exchange IT and systems around modularity, interoperability, flexibility, manageability and security
- Our charge
  - Assess capabilities of pertinent State-owned and operated information systems against this guidance, specifically *EMS*
  - Identify potential for leveraging capabilities of these systems in support of an Exchange, i.e. incorporate existing systems into the *Exchange Information Systems Stack*

Task 9 – Assess existing Medicaid eligibility system and identify interface issues and necessary requirements for integration with the Exchange information technology (IT) infrastructure (cont'd)

- Background – Relevant federal law and guidance:
  - *Guidance for Exchange and Medicaid Information Technology (IT) Systems* version 2.0, May 2011
  - *Exchange Reference Architecture:* Foundation Guidance version 0.99 issued by CCIIO, March 2011
  - *Eligibility and Enrollment Blueprint – Exchange Business Architecture Supplement* version 1.0, May 2011
  - *Harmonized Security and Privacy Framework – Exchange TRA Supplement* version 0.95, March 2011
  - *NPRM re: Medicaid, CHIP and Exchange Eligibility,* August 2011
  - *NPRM re: Exchanges,* July 2011
  - *Enroll 11 Use Case,* July 2011
  - HIPAA
  - Rehab Act

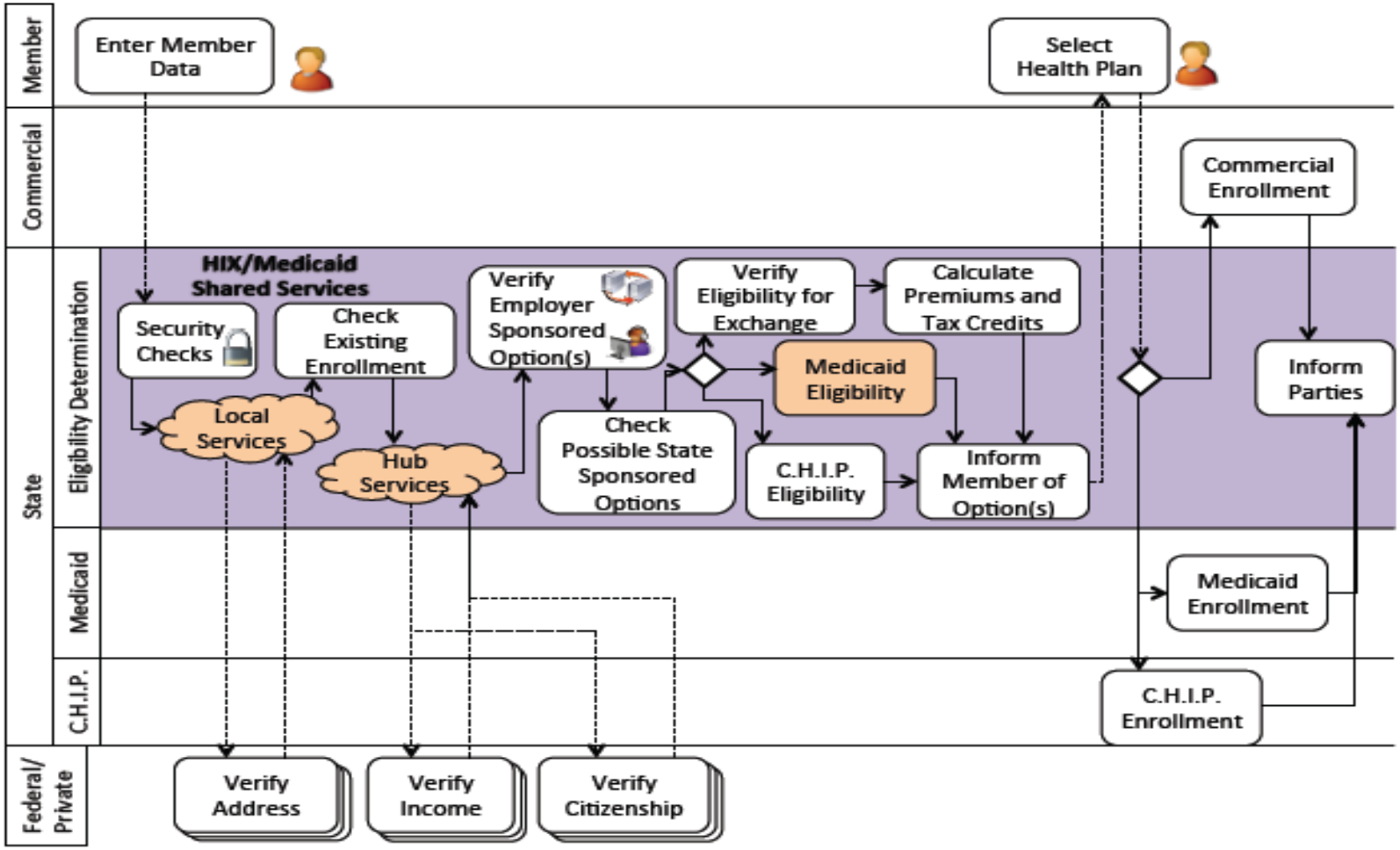
Task 9 – Assess existing Medicaid eligibility system and identify interface issues and necessary requirements for integration with the Exchange information technology (IT) infrastructure (cont'd)

- Analytical framework – from CMS (1 of 2)



Task 9 – Assess existing Medicaid eligibility system and identify interface issues and necessary requirements for integration with the Exchange information technology (IT) infrastructure (cont'd)

- Analytical framework – from CMS (2 of 2)



Task 9 – Assess existing Medicaid eligibility system and identify interface issues and necessary requirements for integration with the Exchange information technology (IT) infrastructure (cont'd)

- Methodology and source information
  - Information system assessment approach, grounded on aforementioned federal laws and guidance, that covered:
    - Functionality
    - Interoperability
    - Security
    - Capacity and availability
    - Accessibility by external users
    - Conformance with CMS IT/information systems standards and conditions
  - Information system assessment tool
  - Targeted interviews with DSS personnel, including CIO Lou Polzella
  - Review of EMS "risk assessment" conducted by Gartner
  - Review of DSS Modernization of Customer Service Delivery (MCSD) plan
  - Assessment of online "customer facing" functionality currently available

Task 9 – Assess existing Medicaid eligibility system and identify interface issues and necessary requirements for integration with the Exchange information technology (IT) infrastructure (cont'd)

- Results
  - Functionality: EMS lacks needed functionality
    - Only 25% of expected functionality is *partially* in place – very little of it being "real time" functionality
  - Interoperability: Numerous historical challenges with interfaces to EMS suggest that the system as architected is not highly interoperable
  - Security: System as architected makes it difficult to restrict access to information per federal guidance
  - Accessibility by external users: Current functionality is very limited and considerably less than expected (reference MCSD initiative)
  - EMS does not conform to CMS IT standards and conditions

As architected, and given programming and support resource constraints, EMS is* not *a viable eligibility and enrollment solution for the Exchange.

Task 9 – Assess existing Medicaid eligibility system and identify interface issues and necessary requirements for integration with the Exchange information technology (IT) infrastructure (cont'd)

- Key considerations
  - Acquisition/development of new eligibility and enrollment solution that could support both Medicaid and the Exchange – not contemplated in MCSD plan, but being explored as part of a separate project
  - Potential to leverage existing contracts for theoretically compatible services, i.e., ACS contract for CHIP administration
  - Potential to leverage "system components" being developed out of the MCSD initiative, particularly those related to "consumer facing" online functionality
  - Potential to leverage "system components" being developed out of the Exchange Early Innovator projects, including New England States Collaborative Insurance Exchange Systems (NESCIES)
- These and other considerations would be addressed as part of the upcoming *Exchange Business Operations and IT Planning* project.

Questions and answers for Task 9

MERCER

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Assess the technical requirements and development of specifications for accounting and financial system functions for the Exchange

Task 8 – Detailed discussion

MARSH & McLENNAN COMPANIES

Task 8 – Assess the technical requirements and development of specifications for accounting and financial system functions for the Exchange

- Summary
  - In the last several months CMS has issued guidance regarding Exchange financial management business process and information systems requirements
  - Previously, CMS had issued more high-level guidance which applied to Exchange information technology and systems around modularity, interoperability, flexibility, manageability and security
  - In-scope business processes include: premium billing, collection, aggregation and disbursement; premium tax credit administration and coordination; cost-sharing assistance administration and coordination; billing and collection of other revenue sources (i.e., carrier assessments for self-sustainability)
  - In-scope business processes also include functions traditionally associated with *Enterprise Resource Planning (ERP)* systems: financial and cost accounting, HR and payroll, supply chain management, asset management, financial reporting, etc.

Task 8 – Assess the technical requirements and development of specifications for accounting and financial system functions for the Exchange (cont'd)

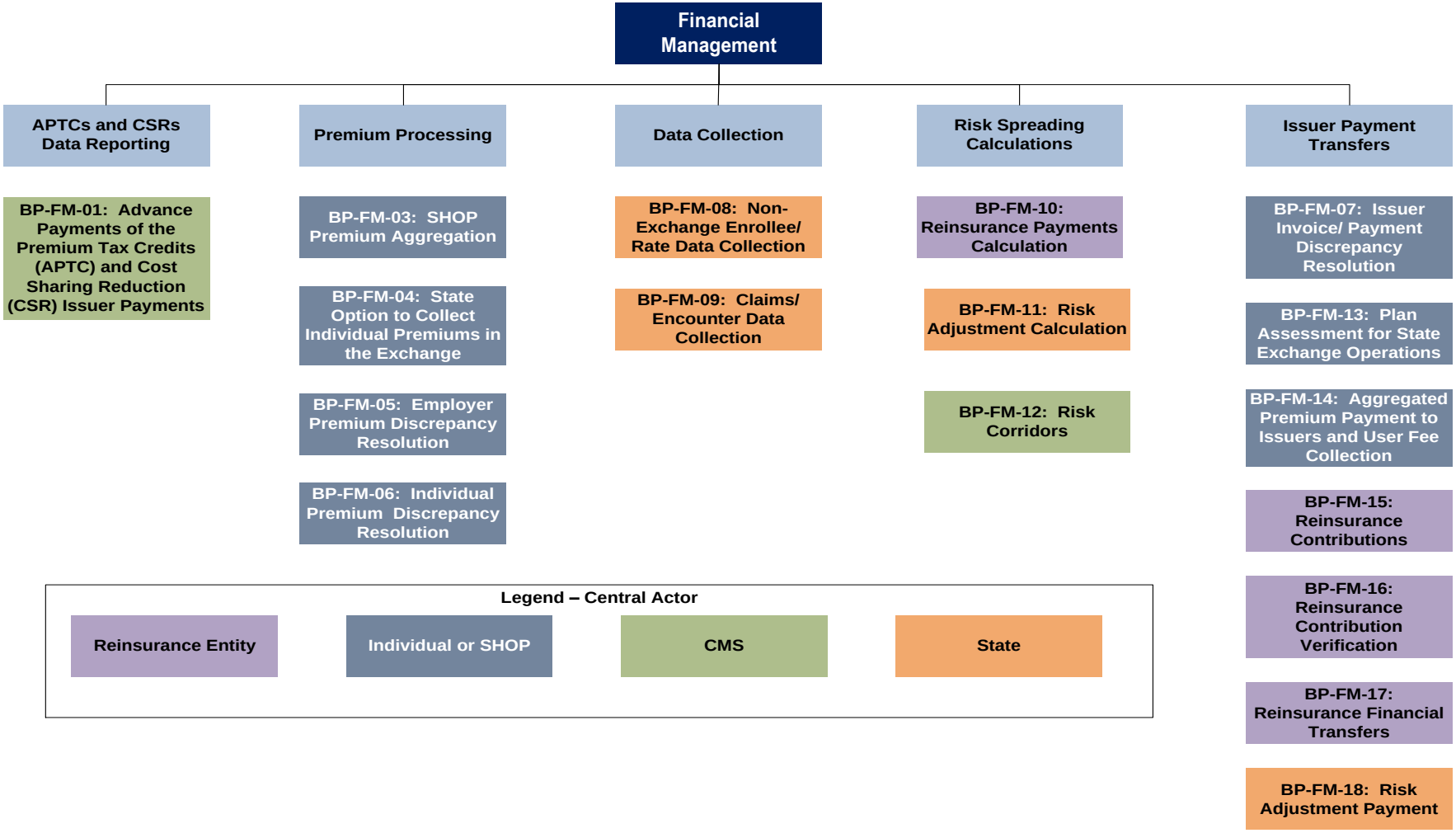
- Our charge
  - Assess capabilities of pertinent State-owned and operated information systems against this guidance, specifically *Core-CT (PeopleSoft)*
  - Identify potential for leveraging capabilities of these systems in support of an Exchange, i.e., incorporate existing systems into the *Exchange Information Systems Stack.*

Task 8 – Assess the technical requirements and development of specifications for accounting and financial system functions for the Exchange (cont'd)

- Background – Relevant federal law and guidance:
  - *Guidance for Exchange and Medicaid Information Technology (IT) Systems* version 2.0, May 2011
  - *Exchange Reference Architecture: Foundation Guidance* version 0.99 issued by CCIIO, March 2011
  - *Financial Management Blueprint – Exchange Business Architecture Supplement* version 1.0, May 2011
  - *Harmonized Security and Privacy Framework – Exchange TRA Supplement* version 0.95, March 2011
  - *NPRM re: Exchanges – Risk Adjustment, Reinsurance, Risk Corridors*, July 2011
  - *Presentations to Exchange Grantee Conference*, September 2011

Task 8 – Assess the technical requirements and development of specifications for accounting and financial system functions for the Exchange (cont'd)

- Analytical framework – from CMS



Task 8 – Assess the technical requirements and development of specifications for accounting and financial system functions for the Exchange (cont'd)

- Methodology and source information
  - Information system assessment approach, grounded on aforementioned federal laws and guidance, that covered:
    - Functionality
    - Interoperability
    - Security
    - Capacity and availability
    - Accessibility by external users
    - Conformance with CMS information systems standards and conditions
  - Targeted interviews with Comptroller's Office personnel, including Thomas Woodruff, Director of Healthcare Policy & Benefit Services
  - Joint completion of information system assessment tool

Task 8 – Assess the technical requirements and development of specifications for accounting and financial system functions for the Exchange (cont'd)

- About Core-CT (PeopleSoft ERP Suite)
  - Deployed in phases beginning in 2003
    - Financials, Phase 1: July 2003
    - HRMS: October 2003
    - Financials: Billing, January 2005; Asset Management, July 2005; Inventory, August 2005
    - Financials: Project costing and customer contracts, July 2007
  - Currently used to support certain elements of the State Employee and Retiree Health Plan

Task 8 – Assess the technical requirements and development of specifications for accounting and financial system functions for the Exchange (cont'd)

- Results (*pending completing and validating the detailed assessment of Core-CT capabilities against Exchange requirements)*
  - It is likely that Core-CT is a viable solution for the ERP functions associated with the Financial Management business area
    - Functionality is there; PeopleSoft is one of the leading ERP solutions
    - State agencies have been using Core-CT for several years
    - As a relatively small organization, the Connecticut Exchange would benefit from not having to acquire or build an Exchange ERP system "from scratch"
  - Until the detailed assessment is complete, we cannot ascertain conclusively whether Core-CT is a viable solution for the other Financial Management functions, particularly premium management, subsidy administration and risk management

Task 8 – Assess the technical requirements and development of specifications for accounting and financial system functions for the Exchange (cont'd)

- Key considerations
  - Early Innovator work: Massachusetts is using a system for premium management which could be leveraged by Connecticut under the auspices of the Early Innovator grant.
  - Core-CT as the Exchange's ERP solution: Would have to work out issues related to:
    - How Core-CT would accommodate the Exchange entity within its architecture
    - Service Level/Business Services Agreement that would have to be structured (between the Exchange entity and the State)
    - One-time and ongoing charges for utilizing Core-CT
- These and other considerations would be addressed as part of the upcoming *Exchange Business Operations and IT Planning* project.

Questions and answers for Task 8

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Analysis of the benefits of a multi-state Exchange or other opportunities to collaborate on Exchange development and operations

Task 11 – Detailed discussion

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Task 11 – Analysis of the benefits of a multi-state Exchange or other opportunities to collaborate on Exchange development and operations

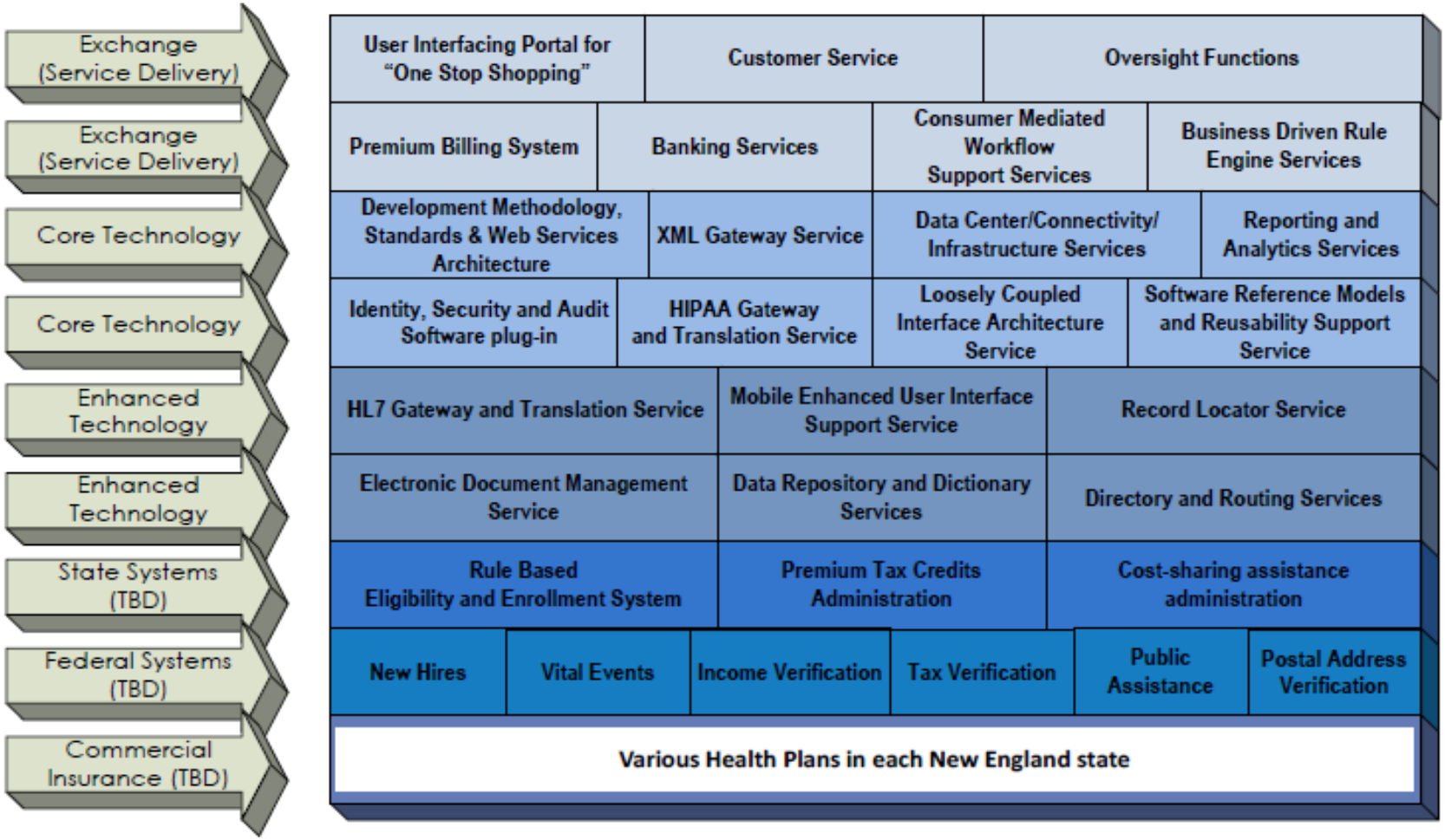
- Summary
  - PPACA permits states to create and join multi-state exchanges
  - Multi-state Exchange operation creates regulatory, legal and practical issues. Connecticut has established the Connecticut Health Insurance Exchange without significant consideration of these issues
  - Other options for Connecticut to leverage external resources for Exchange operation include: 1) utilizing a federal partnership model under which Connecticut shares certain exchange responsibilities with CCIIO and 2) accessing IT functionality from the NESCIES project
  - Mercer team has monitored multi-state development and does not perceive significant opportunities for full-fledged multi-state Exchange operation
  - Mercer team believes the value of federal partnership models is difficult to assess with current information from CCIIO and recommends full review of how Connecticut may leverage NESCIES project artifacts and software to support the operation of the Exchange

Task 11 – Analysis of the benefits of a multi-state Exchange or other opportunities to collaborate on Exchange development and operations (cont'd)

- Background
  - Section 1311 of the PPACA allows states to join with other states (regionally or otherwise) to jointly operate Exchanges
  - Federal effort to get states involved in Exchange implementation has led to definition of "federal partnership models" as something between the "extremes" of state implementation and federal operation
  - Connecticut is a member of the NESCIES project, an "Early Innovator" grant project intended to develop re-usable and adaptable exchange IT components

Task 11 – Analysis of the benefits of a multi-state Exchange or other opportunities to collaborate on Exchange development and operations (cont'd)

New England States Collaborative Insurance Exchange Systems (NESCIES) Component Framework



Task 11 – Analysis of the benefits of a multi-state Exchange or other opportunities to collaborate on Exchange development and operations (cont'd)

- Source information and methodology
  - Review of State legislation
  - Review of federal legislation and associated guidance
  - Informal monitoring and discussions:
    - With Northeast and New England states
    - With NESCIES project leadership
    - With federal actors

Task 11 – Analysis of the benefits of a multi-state Exchange or other opportunities to collaborate on Exchange development and operations (cont'd)

- Results
  - Very little activity to create multi-state exchanges
    - Northeast states have prioritized in-state establishment activities
    - Significant border issues between CT-NY and CT-Mass-RI, but substantially different insurance markets
  - CCIIO effort to define federal partnership models will continue to evolve
    - Option 1: State performs only Plan Management function
    - Option 2: State performs only Consumer Assistance functions
    - Option 3: Options 1 and 2 together
    - All leave very significant operation in federal hands
      - Eligibility
      - Enrollment
      - Financial Management
  - NESCIES is well funded and well run; offers real opportunities for adopting IT functionality

Task 11 – Analysis of the benefits of a multi-state Exchange or other opportunities to collaborate on Exchange development and operations (cont'd)

- Key considerations
  - Federal partnership models will evolve and Connecticut should monitor developments as its Exchange implementation plans take shape
    - Some states may consider models as a first step to buy time
  - Connecticut may benefit from NESCIES outputs, but adapting technology in short timeframes will be challenging
    - Weigh waiting for NESCIES with moving ahead on IT planning
    - NESCIES is an important factor for IT planners to consider from an overall project perspective – many inter-related pieces must come together before mid-2013
  - Any collaboration carries unique risks
  - Any collaboration requires investment of State resources in terms of time and attention just like State-based development

Questions and answers for Task 11

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Next steps

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Next steps

- December 1 Exchange Board meeting
- December 15 Exchange Board meeting

Next steps (cont'd)

- One of the last steps in the planning project is for Mercer to present a draft report that encompasses chapters representing each task and solicit feedback from the State in early December.
- It is our intent to then incorporate the State's feedback into the report and present the final report to Connecticut by December 15.

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Questions and answers

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